

## CERTIFICATE OF MENTAL CAPACITY

*[On the letterhead of the doctor]*

Date: \_\_\_\_\_ Place: \_\_\_\_\_

I am a registered medical practitioner with *[insert appropriate name]* Medical Council.  
My registration number is \_\_\_\_\_.

This is to certify that I have carefully examined *[insert name of person executing the directive]* and hereby certify that *[they]* are fully capable of understanding and taking decisions relating to *[their]* advance medical directive.

[Signature of medical practitioner]